CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 8:020. Independent physical therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C).

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding physical therapy services provided by an independent physical therapist or physical therapy assistant working under the direct supervision of an independent physical therapist.

Section 1. Provider Participation. (1)(a) To be eligible to provide and be reimbursed for physical therapy as an independent provider a provider shall be:

1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

3. A physical therapist.

(b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid program.

(2) Physical therapy provided in accordance with Section 2 of this administrative regulation by a physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in subsection (1) of this section may be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Coverage and Limit. (1) The department shall reimburse for physical therapy if:

(a) The therapy:

1. Is provided:

a. By a:

(i) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced

practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) physical therapy visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each therapy visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for physical therapy provided to a recipient by more than one (1) provider of any program in which physical therapy is covered during the same time period.

(2) For example, if a recipient is receiving physical therapy from a physical therapist enrolled with the Medicaid Program, the department shall not reimburse for physical

therapy provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 CFR 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 Chapter 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 8. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 8:020

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 8:020

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 8:020
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of physical therapy provided by an independently enrolled physical therapist or physical therapy assistant working under the direct supervision of an independently enrolled physical therapist. Currently, the Department for Medicaid Services (DMS) covers physical therapy when provided in a physician's office (and the physician is the billing entity), when provided in an outpatient hospital (when the outpatient hospital is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes physical therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for physical therapy provided to Medicaid recipients. DMS is expanding the physical therapy provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:025, Independent physical therapy service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of physical therapy providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion

group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Any physical therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for physical therapy services provided to Medicaid recipients. Similarly, physical therapy assistants who wish to work for/under the supervision of an independently enrolled physical therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of physical therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many physical therapists will choose to enroll in the Medicaid Program, nor how many physical therapy assistants will elect to work for/under the supervision of

an independently enrolled physical therapists, nor how many Medicaid recipients will receive services from independently enrolled physical therapists.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. A physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide physical therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A physical therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Physical therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of physical therapy services will benefit from an expanded base of providers from which to receive physical therapy services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by $1.43 million ($271,530 state funds/$1.16 million federal funds) for state fiscal year 2014.
(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately $1.91 million ($362,000 state funds/$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 8:020
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

2. State compliance standards. KRS 205.520(3) states:

“Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are not required to cover physical therapy; however, each state’s Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers physical therapy, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state’s Medicaid program to “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 8:020
Agency Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue is anticipated.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue is anticipated.
(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by $1.43 million ($271,530 state funds/$1.16 million federal funds) for state fiscal year 2014.
(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately $1.91 million ($362,000 state funds/$1.55 million federal funds) annually, beginning with state fiscal year 2015.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: